Clinical Violence Intervention: Opportunities and Barriers

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When physicians think about violence, the first images that come to mind are scenes from the criminal justice and legal systems. Professional concern about violent behavior has generally been confined to a subset of psychiatrists. At present, however, a growing number of physicians are beginning to view violence as a public health problem. This approach has flourished under the last several US Surgeons General, beginning in 1985 with C. Everett Koop's unprecedented conference that applied the tools of public health to the problem of violence.

Over the last decade, an explosion has occurred in our understanding of violence, its dynamics, its magnitude, and its role in community life, health, and disease. We are at the dawn of understanding that violence can usefully be seen not only as a public health problem but also as a personal health problem for many patients. We are beginning to develop a clinical response to address violence in the lives of our patients.

The Faces of Violence

Clinicians who address the issue recognize that there are two epidemics of violence within this country. These epidemics overlap, intersect, and share certain characteristics, but remain, nevertheless, two distinct epidemics.

The first is a public epidemic of violence. This epidemic appears on the front pages of newspapers and magazines. It affects young males disproportionately, most particularly inner-city, Afri-

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can-American and Hispanic males. It is shaped by guns and associated with high rates of death. The rate of homicide in the United States is 30 per 100,000. The rate of homicide for African-American youth between the ages of 10 and 34, however, approaches 130 per 100,000. Effectively, this means that more than 1 out of every 1,000 African-American men dies as a result of gunshot injury before reaching middle age.[1]

The toll of this public epidemic of violence is shocking, not only because of its magnitude but also because it affects very young people. The Centers for Disease Control and Prevention (CDC) points out that, in some communities, violence is the leading cause of years of life lost. This public epidemic of violence threatens people and communities in the present, and its differential impact upon young people threatens the nation's future.[2]

In addition to the public epidemic of violence, there is another, private, epidemic of violence. This is the violence within families and intimate relationships. In contrast to public violence, which affects young males, the victims of private violence are predominantly female. Epidemiologically, this private epidemic continues across the life span. The burden of violence against females begins early in life, when the perpetrator is likely to be a father or other male relative, escalates with the onset of battering and rape by dating partners, peaks in the early adult years as domestic violence, and continues, albeit at a lower rate, with the abuse of the elderly.

Twenty years ago, when some researchers estimated that one in five women seen in emergency rooms were victims of domestic violence, their estimates seemed radical.[3] The most recent data, however, which are derived from the experience at 10 Colorado emergency departments, indicate that 1 in 10 women presenting to the emergency department does so because she has been abused, and 50% of women using emergency medical services have been abused at some point during their lives.[4]

These two epidemics—public violence against males and private violence against females—share some common elements. There are extraordinary human costs associated with violence and

the health burden associated with violent injury—of whatever etiology—is profound. In both cases, care of acute injury is only the tip of the human experience and social cost. In addition to emergency services, acute hospitalization, rehabilitation, and prolonged or lifelong physical disability, the victim—and family members—generally suffers serious emotional and mental distress. For example, children who frequently witness violence display high levels of dysfunction and an inability to participate actively in community life and schooling. The identification and resolution of "post-traumatic stress" is an important component of recovery from any violent event.

Living in a violent relationship—the crux of the private epidemiology of violence—poses a unique and predictable increased risk. Battered women describe living in violent relationships as 'walking on eggshells' and suffer, not *post-traumatic*, but *intra-traumatic stress*. Individuals respond to such stress in predictable ways: some lose their appetites, some develop headaches, some have stomach pains, others become depressed. The result is a host of primary care problems associated with the chronic stress of living within a violent relationship.

Examining the experience of battered women suggests that ongoing violence and increasing stress appear as the background for some of the most vexing health problems that women face today. We estimate, for example, that 45% of female alcoholism begins with domestic violence; 10% of illicit substance abuse by females begins in domestic violence; and, for women who already are involved with illegal substances, almost 100% are involved in violent relationships. Approximately 30% of cases of female depression and 25% of suicide attempts by females can be related to domestic violence. Increasingly, we recognize that there is an overlap between abuse of children and abuse of mothers in violent families. Studies in Boston suggest that the rate of overlap is as high as 60%.[5] It is stunning to consider that we have been addressing child abuse for almost 30 years, yet are only now beginning to recognize the high rates of abuse directed against mothers in these families.

Violence as a Harbinger of Health Outcomes

The extraordinary costs of violence and its sequelae can be glimpsed even in the most cursory summary of these twin epidemics. Violence prevention—both primary and secondary—has vast repercussions. Perhaps what is most important for clinicians to truly understand, therefore, is that *violent injury is a sentinel health event.* When a patient presents for treatment of an injury caused by violence, the episode predicts future health risk; it predicts that bad things will happen. A 17-year-old African-American male coming into an urban emergency room with a gunshot wound has a shorter life expectancy than his brother who has been diagnosed with HIV infection. A sexually abused adolescent risks unintended pregnancy, sexually transmitted disease, depression, and substance abuse. The battered woman faces recurrent assaultive injuries, long-term health problems secondary to trauma, and poor pregnancy outcomes, as well as increased rates of mental illness, suicide attempts, and substance abuse. Violence is a sentinel health event for both the community and the individual involved—we can no longer view it as simply a criminal justice problem.

Modern medicine is growing accustomed to using population-based surveillance data. With the widespread advent of managed care, there is an opportunity for improved surveillance data to better understand violence as a sentinel health event. That understanding will have repercussions across the entire health-care system.

The emphasis on health maintenance in managed care suggests that all health-care professionals will be called on to address the issue of violence in our communities as we more accurately recognize its toll on community well being. Potentially, the centralization of delivery services will allow both patients and providers access to new resources in counseling and new skills to facilitate behavioral change. The major shifts that physicians have already made related to smoking, safe sex, diet, and exercise, suggest that physicians are in fact becoming accustomed to addressing behav-

ioral issues, and, building on these experiences, will be able to contribute substantially to the prevention of violence and amelioration of its health and social effects.

In the next decade, organizations such as the Institute of Medicine, which has addressed the mind-body split over the last 25 years, have an opportunity to address what we might call the community-mind-body split. That is a new frontier for medicine, but is one that is opening because of the current reorganization in health care.

Toward Interdisciplinary Treatment of the Violence Epidemics

Medical professionals have already seen the transformation of several criminal justice problems to medical problems. Alcoholism, drug abuse, and even psychosis were all once considered to be substantially law-enforcement problems. We have learned to recognize that behavioral-social problems affect both individual health and community health, and to address these issues through interdisciplinary efforts. Some individuals involved are identified through the criminal-justice system; others, through the health-care system. Some interventions are based on a criminal-justice model; others, on a medical model. Interdisciplinary action is now well accepted in public health and integrated, interdisciplinary, coordinated care is the model for clinical practice as well.

Violence is not an easy problem to treat, nor will it be easy to build alliances with the criminal-justice system. Even when such alliances are developed, how are we to evaluate the collaboration between medicine and law, health and justice, as we address violence?

Whatever innovations are made, they must stand the test of classical measures—that the changes instituted do no harm. This has always been the first priority in medicine, but we need to understand how to translate this outcome into community terms.

Many physicians have learned, by working on issues such as bereavement, perinatal loss, and HIV infection, that the process

matters if we are to enhance community strength. As far as patients are concerned, it is not just outcome, it is the process that counts; this is even more true on a community level. We will need to evaluate not only whether an individual patient is better but also whether the community is better because of the actions taken and programs instituted.

Physicians dealing with the epidemics of violence, above all, should retain a global view of their actions. It bears repeating: the ultimate measure of success will not be solely the health status of an individual patient. The final measure is whether our communities are healthier, safer, and more cooperative. Therefore, while recognizing violence as an extraordinary epidemic in public and private life, one that is a sentinel event in personal and community health, the opportunity to join in partnership with law will demand and encourage an evaluation system that integrates justice and human rights into current concepts of clinical outcome measures.

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